

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>010888</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/08/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>STERLING HOUSE OF RICHMOND</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3700 S A ST RICHMOND, IN 47374</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: October 4, 7, and 8, 2013</p> <p>Facility number: 010888 Provider number: N/A AIM number: N/A</p> <p>Survey team: Barbara Gray RN TC Leslie Parrett RN (October 7 and 8, 2013) Angel Tomlinson (October 7 and 8, 2013)</p> <p>Census bed type: Residential: 37 Total: 37</p> <p>Census payor type: Other: 37 Total: 37</p> <p>Sample: 7</p> <p>Sterling House of Richmond was found to be in compliance with 410 IAC 16.2 in regard to the State Licensure Survey.</p> <p>Quality Review 10//13 by Lisa McColly</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE